DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO AN APPARENT SUICIDE OF KB

Thirty- four year-old, female resident of Western State Hospital, died from an apparent suicide.

DRVD CASE# 95-0604M
Department For Rights of Virginians With Disabilities
Fishersville Field Office
Beth Chadwell, Advocate
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1. INTRODUCTION:

This report is a summary of the findings from the Department For Rights of Virginians With Disabilities' (DRVD's) investigation into the death of KB, a 34 year-old, African American female, who was a resident at Western State Hospital (WSH) in Staunton, Virginia. KB was found dead in her bed at WSH from an apparent suicide at approximately 6:00 AM on 9/10/95.

DRVD conducted this investigation of an alleged incident of abuse and/or neglect of an individual with mental illness pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986.

DRVD's investigation included the following:

1. Reviewing the Client's medical records at WSH.
2. Interviewing WSH Risk Manager regarding the Client.
3. Reviewing Virginia State Police Investigative Report concerning this incident.
4. Reviewing Virginia Medical Examiner's Report regarding the Client.
5. Reviewing WSH Security Report concerning this incident.
6. Interviewing the Client's mother.

II. BACKGROUND:

KB was a 34 year-old, African American female, diagnosed with Schizoaffective Disorder, who recently relocated with her mother from New York to Virginia. She was voluntarily admitted to Blue Ridge Hospital (BRH), a private mental health facility in Charlottesville, Virginia on 8/13/95, as a result of experiencing

hallucinations to harm her mother. On the night of 8/13/95, after admission to BRH, KB was found by staff in the women's shower room trying to hang herself w/a sheet over the shower head. KB was subsequently prescreened and involuntarily committed to BRH as a result of this dangerous intent to harm herself. KB stated, "I've been thinking about doing it for awhile" and reported her past attempt about a year ago of overdosing on pills. KB was transferred to WSH, a state mental health facility in Staunton, Virginia on 8/29/95 from BRH as a result of her need for further psychiatric treatment and stabilization.

KB had a long history of schizoaffective disorder and a history of multiple psychiatric admissions in different states since the age of 22. She was diagnosed with paranoid schizophrenia in 1991. She had a history of cutting her wrists in New York in 1994 and most recent hospitalizations include Nassau County Hospital, New York, in January 1995, and BRH from 7/15/95 -7/25/95. KB's past physician, conveyed to WSH staff, her history of suicidal gestures appeared to have occurred simultaneously with moving and changing therapists. KB's mother was very supportive and maintained a very close relationship with her daughter up to her death on 9/10/95.

According to records from WSH, KB's final psychiatric diagnoses at the time of death were as follows:

1. Axis I: Schizoaffective Disorder, Bipolar Type 295.70
2. Axis II: No Diagnosis V71..09
3. Some Cluster B (Borderline) Traits
4. Axis III: Cardiopulmonary Arrest Secondary to Asphyxia/Suffocation - Self Induced
5. Hypothyroidism Secondary to Thyroid Ablation following treatment for Grave's Disease; H/O Genital Herpes

Records indicate at the time of KB's admission to WSH on 8/29/95, she was being treated with the following medications, prescribed for her by BRH:

1. Depakote 250 mg. qam, 500 mg. qhs
2. Resperidone 3 mg. bid
3. Synthroid .175 mg. qam

KB's medication record as of September 1995 reflected she was being treated with the following medications by WSH at the time of her death:

1. Resperidone 6mg qhs
2. Synthroid .175 mg qam
3. Valproate 500 mg. bid

III. CIRCUMSTANCES SURROUNDING THE DEATH OF KB:

A. Care provided to KB at WSH

KB was transferred to WSH from BRH on 8/29/95 and was assigned to Ward B1 Admission Unit for evaluation and further treatment. KB's WSH record showed upon admission, she was checked for contraband and none was found. The record also shows KB was able to contract against self-harm and was assessed by staff not to be suicidal upon admission.

In the early morning of 8/31/95, KB complained to ward staff of anxiety and was noted to be tearful and afraid she might hurt herself. Ward staff responded to KB by assessing her and concluded she denied suicidal ideation. As a result, KB contracted with staff not to harm herself or others and was given a PRN of Ativan to help alleviate her anxiety. KB then went to her bedroom where she was observed by ward staff a few hours later to be asleep and resting comfortably. During midday, on 8/31/95, KB was observed by ward staff in the dayroom to be standing on a chair hanging a sheet over the door return trying to tie it in a knot. When asked by ward staff what she was doing, KB responded with "I don't know." She also stated, "They shouldn't have taken me off my medications - don't they know it makes me feel bad when I don't get it."

As a result of this suicidal gesture, KB's treatment team implemented a treatment plan for her which provided for intervention to address her verbalizations or gestures of self harm. KB's treatment plan provided for KB to be placed in her room, sitting in a chair, in four-point leather restraints with a posey vest. KB was to remain in restraints for up to 8 hours or until calm for 30 minutes. Upon release from restraints, KB's bed was to be placed in the dayroom for observation with dayroom restriction until reassessed by treatment team. KB's record indicated she was checked hourly by staff while in restraints and after 5 hours in restraints in her room, KB was released and determined by staff to have been calm for at least 30 minutes. At the time of her release from restraints, KB was able to contract with staff that she would tell them if she had any feelings of hurting herself or others.

At approximately 11:00 PM on 8/31/95, KB became loud and agitated. She was given a PRN of Vistaril 50 mg. and then returned to her cot in the dayroom. The treatment team met on the morning of 9/1/95 and discontinued the need for her bed to remain in the dayroom.

KB was placed in time out the morning of 9/9/95 for verbal threats to other residents on the ward and released 3 hours later based on her ability to remain calm for at least 30 minutes.

KB's medical record indicated she had hypothyroidism as a result of being treated for Graves Disease and had a history of genital herpes. The record also indicated KB had repeated complaints of headache pain several days prior to her death on 9/10/95, which were treated with Tylenol.

KB's progression in the ward program had very much improved from her date of admission. She had been attending more groups and activities and was getting along well with the other residents on the ward. KB was restricted to the ward her entire hospitalization and did not, at any time, have on or off grounds privileges.

B. September 10, 1995 Sequence of Events

At 4:00 AM, on 9/10/95, KB was observed by staff to go to the bathroom and return to her room. At 5:00 AM, KB was checked by staff and was observed to be in her room sleeping at that time. At 6:05 AM, staff went to KB's room to awaken her for breakfast and found her lying in her bed on her back with 3 plastic bags over her head and a nylon stocking tied around her neck. KB's roommate was on pass; therefore, no one else was sleeping in the room that night. Upon finding KB, staff reported KB's skin to be warm to the touch and began CPR administration immediately. At 6:10 AM, 911 was called by staff and the Staunton/Augusta Rescue Squad arrived minutes later on the scene for medical assistance. Resuscitation efforts were stopped after 30 minutes. Time of death was called at 6:32 AM by the WSH physician on call. Staff found a note on KB's nightstand bedside her bed, indicating KB committed suicide, along with a 28-page letter to her father.

The psychiatric aide who found KB stated she had checked on KB at approximately 5:00 AM and that she was sleeping. She did not notice anything unusual. She checked again at 6:05 AM and found KB lying in her bed on her back with plastic bags on her head and stockings around her neck. She took one bag off KB's head and found another and another for a total of three bags. She stated the stockings were not tight and that they pulled off "real easy." She stated she yelled for assistance and at that time another staff person entered the room and helped her pull KB from the bed onto the floor to initiate CPR. She stated two additional staff entered the room and assisted in administering CPR. The Staunton/Augusta Rescue Squad arrived and attempted to get an IV into KB and also shocked her to

get her heart going. The Doctor on Call arrived at approximately 6:32 and pronounced KB dead.

The Registered Nurse who assisted with KB's resuscitation efforts concurred with the information given by the psychiatric aide who found KB, with the only addition being she found the notes (suicide) on the nightstand beside KB's bed.

C. Investigations

The Virginia State Police investigated the incident and no criminal neglect was found to have occurred in the death of KB.

The Chief Medical Examiner's autopsy report determined the cause of death to be asphyxia due to plastic bag over head and the manner of death to be suicide.

IV. FINDINGS AND CONCLUSIONS:

This investigation failed to reveal evidence that abuse or neglect was involved in either KB's care and treatment at WSH or in her death on September 10, 1995. KB's WSH record indicated her treatment plan and WSH Hospital Instruction Number 4011 - Special Observation and Monitoring of Patients, were correctly followed for her verbalizations or gestures indicative of harm to self or others. When KB verbalized thoughts of harm to herself or others, she was placed in four-point restraints with posey vest, sitting in a chair in her room, with hourly checks by staff, and released when calm for at least 30 minutes. Upon release from restraints, KB's bed was placed in the dayroom and she was placed on dayroom restriction until the treatment team met to discuss her behavior.

Staff witness testimony concurred as to the events which occurred after finding KB's body on 9/10/95.

Resuscitation efforts were attempted for approximately 35 minutes by WSH staff and Rescue personnel, with the WSH doctor on call pronouncing KB dead at 6:32 AM.

V. RECOMMENDATIONS:

KB's mother, based on her concerns regarding the care and treatment of her daughter while at WSH, submitted a list of recommendations, through DRVD, to the WSH Director. DRVD met with the WSH Director on 12/20/95 to discuss the recommendations made by KB's mother. They were as follows: 1) the need for

routine ward checks by staff for harmful or dangerous items; 2) the need for more physical staff presence in the WSH admitting office for supervision purposes; 3) the need for close observation of all residents on an acute admissions ward, who are or who have been suicidal. The WSH Director indicated verbally during this meeting that the facility had undertaken various activities as a result of KB's death. These activities included recurrent discussions of the incident in QA meetings; a literary search regarding suicide risks in psychiatric facilities; preparation of mandatory training for all direct care staff related to managing suicide risks; and a benefit/risk assessment regarding use of plastic bags in the facility. This information was relayed to KB's mother, and she requested the information in writing. The WSH Director would not release this information in writing to her.

Due to a lack of sufficient evidence substantiating either abuse or neglect, it is recommended this investigatory case be closed by DRVD.